Section 4: Managed Care Provider Information

Carolina ACCESS—Community Care of North Carolina

The two primary care case management Medicaid programs in North Carolina, Carolina ACCESS (CA) and ACCESS II/III, have been combined to form Carolina ACCESS/Community Care of North Carolina (CA/CCNC). For the purposes of this manual, the term CA/CCNC will be used to identify these programs. A majority of Medicaid recipients in all 100 counties in North Carolina are enrolled in CA/CCNC. DMA contracts with primary care providers (PCPs) to create medical homes for all CA/CCNC enrollees. PCPs are reimbursed on a fee-for-service basis according to the Medicaid rate schedule.

Carolina ACCESS

Carolina ACCESS was initiated in 1991 as Medicaid's primary care case management (PCCM) program. Carolina ACCESS was developed to provide Medicaid recipients with a medical home, which provides access to the public and private medical provider community. Enrolling recipients into a medical home reduces the need for recipients to seek basic sick care services from hospital emergency departments. PCPs coordinate care for enrollees by providing and arranging for the recipient's health care needs.

Participating Carolina ACCESS PCPs receive a monthly management fee of $1.00 per member per month for coordinating the care of Medicaid recipients enrolled with their practice(s). They also receive fee-for-service Medicaid reimbursement for the medical services provided to their patients.

Community Care of North Carolina—ACCESS II/III

Community Care of North Carolina, formerly known as ACCESS II/III, was initiated in 1996 as a community-based enhanced PCCM program bringing PCPs, hospitals, health departments, DSSs, and other community providers into a network to manage the health care needs of Medicaid recipients. Each CCNC regional network employs care managers who assist in developing, implementing, and evaluating the care management strategies at each site. These care management strategies include

- Performing risk assessment—utilizing an "at-risk" screening tool that identifies both medical and social risk factors
- Reviewing emergency department utilization—integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees
- Implementing disease management processes—including, but not limited to, pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes
- Implementing a care management process—identifying and targeting care management activities based on the screening process and other methods of identifying enrollees at risk
- Identifying high costs and high users—developing and implementing activities that lower utilization and cost

- Developing pharmacy initiatives to alleviate the high cost of medications

Currently, there are 14 CCNC regional networks that include more than 3,000 physicians across North Carolina. PCPs who affiliate with a network receive $2.50 per enrollee per month. Each CCNC network is governed by a local administrative entity, which is paid an additional $3.00 per enrollee per month to develop and implement care management strategies. CCNC is jointly administered by the Office of Research, Demonstration, and Rural Health Development and DMA. The following is a list of the networks in CCNC:

The following are the administrative entities for CCNC:

ACCESSCare, Inc.
ACCESS II Care of Western North Carolina
ACCESS III of Lower Cape Fear
Carolina Collaborative Community Care
Carolina Community Health Partnership
Community Care of Wake/Johnston Counties
Community Care Partners of Greater Mecklenburg
Community Care Plan of Eastern Carolina
Community Health Partners
Northern Piedmont Community Care
Northwest Community Care Network
Partnership for Health Management
Sandhills Community Care Network
Southern Piedmont Community Care Plan

Recipient Enrollment

The county DSS is responsible for recipient enrollment in managed care programs. CA/CCNC enrollment is mandatory for the majority of Medicaid recipients. Medicaid recipients who are not required to enroll in managed care have the option of selecting a managed care PCP. For example, recipients who receive both Medicare and Medicaid are not mandated to enroll in CA/CCNC; however, they may choose to enroll.

Medicaid recipients who enroll in CA/CCNC, whether as a requirement or an option, must select a medical home from the list of PCPs serving their county of residence. Recipients who do not choose a medical home may be assigned to a medical home by the county based on location, medical history, and other factors. Each family member may have a different medical home.

Enrollees may request to change their medical home at any time. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Enrollment is limited to 2,000 recipients per physician or physician extender, unless otherwise approved by DMA.

Enrollees are responsible for all co-payments required by Medicaid. Refer to **Co-payments** on page 2-18 for additional information.

CA/CCNC enrollees are identified by information on their MID card. "Carolina ACCESS Enrollee" appears on the card along with the name of the medical home, address, and daytime and after-hours telephone numbers.

Refer to **Verifying Eligibility** on page 2-12 for information on verifying recipient eligibility.

Recipient Education

The county DSS is responsible for recipient education. Enrollees are provided with a Carolina ACCESS recipient handbook (available in English and Spanish) that informs them of their rights, responsibilities, and benefits of being a member. It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CA/CCNC PCPs are strongly encouraged to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly **Carolina ACCESS Provider Enrollment Report**. Refer to page 4-20 for an example of the report.

Providers should inform each enrollee about

- The availability of medical advice 24 hours a day, 7 days a week, and the preferred method for contacting the PCP
- The enrollee's responsibility to bring the **current** month's Medicaid card to each appointment
- The need to contact the PCP for a referral before going to any other doctor
- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for enrollees from the county DSS
- Co-payment requirements

Provider Participation

Requirements for Participation

DMA Provider Services and DMA Managed Care work together to recruit and enroll PCPs into the CA/CCNC program. DMA Provider Services is responsible for processing the applications and enrolling providers into the program. DMA Managed Care is responsible for establishing PCP participating requirements, assisting providers in carrying out CA/CCNC policies and procedures, and recruiting providers into the program. Questions about the CA/CCNC program or requirements for participation can be answered by the regional managed care consultants or by contacting DMA Managed Care at 919-647-8170.

DMA requires providers to complete and submit a signed application and agreement indicating their compliance with all participation requirements. The **CA Provider Enrollment Packet is available** on DMA's Web site at http://www.ncdhhs.gov/dma/caenroll.htm. The application and the agreement must each contain the original signature of the authorized representative (or a participating provider). Applications may be pended for a maximum of 90 days from the date of receipt of the application by DMA Provider Services. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time

unless a sanction has been imposed upon the provider's participation by the Managed Care Section.

Every DSS is notified weekly of new CA/CCNC providers and changes in current CA/CCNC provider information. Providers are required to report any changes regarding their practice's status to DMA Provider Services. To report changes to the Medicaid program, CA/CCNC providers must submit a signed **Medicaid Provider Change Form** (see **Appendix G-3**).

To be approved as CA/CCNC PCPs, providers must meet the following requirements:

1. Accept N.C. Medicaid payment as payment in full, practice in the state of North Carolina or within 40 miles of the borders of North Carolina, and have an active N.C. Medicaid provider number for use as the CA/CCNC provider number.
2. Have an active license for each provider in the practice. Each physician and doctor of osteopathy must also have an active individual Medicaid provider number. Participating nurse practitioners and certified nurse midwives who have been issued individual Medicaid provider numbers must also disclose their individual provider numbers on the CA/CCNC provider application. The information on file for each individual Medicaid provider number must be consistent with the information provided in the CA/CCNC application.
3. Be enrolled as one of the following Medicaid provider types:
   Family medicine
   Gynecologists
   General practitioners
   Internists
   Nurse practitioners
   Federally qualified health centers
   Osteopaths
   Health departments
   Pediatricians
   Rural health clinics
   Obstetricians

   Note: Physician assistants do not directly enroll in Medicaid at this time, but may participate in Carolina ACCESS through their supervising physician and enroll with Carolina ACCESS using the supervising physician's Medicaid number.
4. Enroll each CA/CCNC location with a separate, site-specific provider number. Practices operating as a group must enroll with a site-specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the N.C. Medicaid program, and must therefore be site specific. The CA/CCNC PCP's practice name, address, and daytime and after-hours telephone numbers are printed on the enrollee's MID card.
5. Enroll with CA/CCNC using a group number, if applicable, for ease of claims filing, referrals, management of reports, and accurate financial reporting to the IRS.

   Note: Pending National Provider Identifier (NPI) implementation, all CA/CCNC management fees are generated under the Medicaid provider number, which is also the authorization given to other providers of service when appropriate. After NPI implementation, the authorization given for services when appropriate will be your NPI number. For more information about NPI, see http://www.ncdhhs.gov/dma/NPI.htm.
6. State on the initial application the maximum number of enrollees that will be accepted for the site and also any specific enrollment restrictions such as age or gender. Enrollment of Medicaid recipients is capped at 2,000 per participating provider (MD, DO, PA, NP, or CNM).

   Note: Providers who do not accept Medicare shall not have CA/CCNC enrollees who have Medicare coverage assigned to their practice.
7. List on the application all contiguous counties from which the practice will accept CA/CCNC enrollees. Since the provider must be accessible for primary care, these

counties must include only the county in which the practice is located and the bordering counties.

8. Disclose on the application information regarding sanctions or termination by the Medicaid program or the Carolina ACCESS program. For complete information, refer to **Sanctions** on page 4-6.
9. Establish and maintain hospital admitting privileges or enter into a formal agreement with another physician or group practice for the management of inpatient hospital admissions of CA/CCNC enrollees. If the CA/CCNC practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the N.C. Medicaid program, then the **Carolina ACCESS Hospital Admitting Agreement** form must be submitted to DMA Provider Services to address this requirement for participation.
10. Have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week.
11. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. Refer to **24-Hour Coverage Requirement** on page 4-8.
12. Make oral interpretation services available free of charge to each current and potential enrollee. This applies to all non-English languages.
13. Make primary care services available to enrollees and indicate these services on the application. These services must encompass all requirements for the specified ages. For example, a provider who wishes to enroll recipients ages 2 through 20 must agree to provide all components for each age category, 2 through 20.

    Note: PCPs who request CA/CCNC participation for Medicaid for Pregnant Women (MPW) enrollees only are exempt from the preventive and ancillary services requirements.

Conditions of Participation

When a provider agrees to participate with CA/CCNC, s/he agrees to

- Develop patient–physician relationships
- Manage the health care needs of recipients
- Provide mandatory preventive services
- Authorize and arrange referrals, when necessary, for health services that the primary care practice does not provide
- Review and use recipient utilization, emergency room enrollment, and referral reports
- Follow standards of appointment availability

In addition to the conditions of participation for Medicaid providers beginning on page 3-2, CA/CCNC providers must comply with section 1932 (b)(7) of the Social Security Act, which states, “the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider’s license or certification under applicable State law solely on the basis of provider’s license or certification.”

Exceptions

Exceptions to a requirement for participation may be granted in cases in which it is determined that the benefits of a provider's participation outweigh the provider's inability to comply with this requirement. The provider shall submit a written request to DMA for consideration for exception for a specific agreement requirement. The request shall include the reasons for the contractor's inability to comply with this agreement. The request shall be submitted at the time this agreement is submitted to DMA for consideration. Approval of the application constitutes acceptance of the request for exception.

Sanctions

Failure to meet the terms outlined in the CA/CCNC provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly management/coordination fee may be withheld.
- The PCP may be referred to DMA Program Integrity (PI) for investigation of potential fraud or for quality-of-care issues.
- The PCP may be referred to the N.C. Medical Board.
- The PCP may be terminated from the CA/CCNC program.

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered; or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

Sanction Appeals

The PCP is notified by certified mail of the sanction and the right to appeal the sanction.

DMA must receive the PCP's request for a formal evidentiary hearing by the DMA Hearing Unit no later than 15 calendar days after the receipt of the sanction notice. The hearing provides an opportunity for all sides to be heard in an effort to resolve the issue. The sanctioned party may represent himself or herself, may designate a representative, or may enlist the services of an attorney. The findings are documented by the DMA hearing office and presented to the DMA Director, who makes the final determination to uphold or rescind the sanction. The PCP is notified by certified mail of the Director's decision.

PCPs who are terminated from the CA/CCNC program—or who voluntarily withdraw to avoid a sanction—are not eligible to reapply for a minimum of one year, with a maximum time period to be determined by the Managed Care section. The decision is predicated on the extent or severity of the contract violation necessitating the termination.

Terminations

The PCP's agreement to participate in the CA/CCNC program may be terminated by either the PCP or DMA, with cause, or by mutual consent, upon at least 30 days' written notice delivered by registered mail, return receipt requested. Termination will be effective on the first day of the month, pursuant to processing deadlines.

Provider Reports

The goals of the CA/CCNC program are to improve access to primary care and to provide a more effective and cost-efficient health care system. It is the responsibility of PCPs to effectively manage the care of their enrollees. DMA provides four reports to assist PCPs with this goal.

Enrollment Report

DMA's Managed Care section provides PCPs with a monthly **CA Provider Enrollment Report**. The report consists of three sections for both Carolina ACCESS enrollees and N.C. Health Choice enrollees if applicable: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the managed care consultant or the county DSS. PCPs must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported, until the change or error has been resolved and reported correctly. Refer to page 4-20 for an example of the report.

Emergency Room Management Report

The **Emergency Room Management Report** lists the PCP's enrollees for whom emergency department services were paid during the month. It is very important to review this report to determine enrollees who are using the emergency department inappropriately and to develop strategies to redirect these enrollees to the appropriate setting. PCPs may need to evaluate their after-hours message or procedures or collaborate with an urgent care center to provide the most cost-effective after-hours care. Refer to page 4-23 for an example of the report.

Referral Report

DMA provides CA/CCNC PCPs with a monthly **Referral Report** containing information on where and when enrollees obtained services during the month. The report is available to PCPs on paper or diskette. Refer to page 4-24 for an example of the report.

Quarterly Utilization Report

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost-effective primary care. An example of the report and instructions for using it are available beginning on page 4-25.

Provider Requirements

Health Check Services

CA/CCNC PCPs are required to provide Health Check preventive care screenings to Medicaid-eligible children aged birth through 20 years. PCPs serving this population who do not provide Health Check screenings are required to pursue an agreement with the local health department to provide all Health Check screening components. PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer to **Appendix G-10** or to DMA's Web site at http://www.ncdhhs.gov/dma/forms.html for a copy of the **Health Department Health Check Agreement.**

Refer to the **Health Check Billing Guide,** which is printed every year as a special bulletin, for screening requirements. The special bulletin will be located on DMA's Web site at www.ncdhhs.gov/dma/bulletin.htm.

Adult Preventive Annual Health Assessments

CA/CCNC PCPs are required to provide all of the components of an initial preventive annual health assessment and periodic assessments to adult enrollees aged 21 years and over. For more information, please refer to "Clinical Preventive Services for Normal Risk Adults Recommended by the U.S. Preventive Services Task Force" at http://www.ahrq.gov/clinic/uspstfix.htm.

24-Hour Coverage

CA/CCNC requires PCPs to provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. There must be prompt (within 1 hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by the office staff during regular office hours.

PCPs must provide enrollees with an after-hours telephone number. The after-hours number may be the PCP's home telephone number. The after-hours telephone line must be listed on the enrollee's MID card. The after-hours telephone number must connect the enrollee to one of the following:

- an answering service that promptly contacts the PCP or the PCP-authorized medical practitioner
- a recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner
- a system that automatically transfers the call to another telephone line that is answered by a person who will promptly contact the PCP or PCP-authorized medical practitioner
- a call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours, or is answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care, is **not acceptable.** It is **not acceptable** to refer enrollees to the PCP's home telephone if there is no system in place as outlined above to respond to calls. PCPS are **encouraged** to refer patients with urgent medical problems to an urgent care center.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- Emergency care—immediately upon presentation or notification
- Urgent care—within 24 hours of presentation or notification
- Routine sick care—within 3 days of presentation or notification
- Routine well care—within 90 days of presentation or notification (15 days if recipient is pregnant)

Emergency Conditions—An emergency medical condition is one in which the sudden onset of a medical condition, including emergency labor and delivery, manifests itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in

- serious jeopardy to the health of the individual or the health of a pregnant woman or her unborn child
- serious impairment to bodily functions
- serious dysfunction of any body organ or part

With regard to pregnant women having contractions, a situation is considered to be an emergency if

- there is inadequate time to effect a safe transfer to another hospital before delivery; or
- transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Conditions—An urgent medical condition is defined as a condition that, without medical attention and intervention within 12 to 24 hours, could seriously compromise the patient's condition and the possibility of a full recovery.

Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- Walk-ins—within 2 hours, or schedule an appointment within the standards of appointment availability
- Scheduled appointment—within 1 hour
- Life-threatening emergency—must be managed immediately

Hospital Admitting Privileges

CA/CCNC PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CA/CCNC enrollees. An appropriate arrangement must be made to ensure access to care for all enrollees regardless of age. The **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement form** fulfills this requirement for participation by serving as a voluntary written agreement between the CA/CCNC signing the agreement, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the enrollee throughout the enrollee's inpatient stay. **This agreement must be completed by both parties**. The CA/CCNC PCP must submit the original form with his or her application for participation or when a change occurs regarding the provider's admitting agreement. A copy of the admission agreement is in **Appendix G-13** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html.

The following arrangements are acceptable:

- A formal agreement may be made with a physician, a group practice, a hospital group, or a physician call group.
- The physician, group practice, or hospital group need not be a CA/CCNC provider, but must be enrolled with the N.C. Medicaid program.
- Admitting privileges or formal arrangements must be maintained at a hospital that is within 30 miles or 45 minutes' drive time from the PCP's office. If there is no hospital that meets these geographic criteria, the closest hospital to the CA/CCNC PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases in which it is determined the benefits of a PCP's participation outweighs his or her inability to comply with the admitting privileges requirement.

Women, Infants, Children Special Supplemental Nutrition Program Referrals

Federal law mandates coordination between Medicaid managed care programs and the Women, Infants, Children (WIC) program. CA/CCNC PCPs are required to refer potentially eligible enrollees to the WIC program. Copies of the **WIC Exchange of Information Form for Women**, the **WIC Exchange of Information Form for Infants and Children**, and the **Medical Record Release for WIC Referral form** are available in **Appendix G-14, -16,** and **-18** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html.

For more information, contact the local WIC agency at the DSS or the Division of Maternal and Child Health at 1-800-FOR-BABY (1-800-367-2229).

Transfer of Medical Records

CA/CCNC PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request.

Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the CA/CCNC program and approved by the Physician Advisory Group. All CA/CCNC PCPs must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CA/CCNC PCPs. Refer to **page 3-3** for medical records standards that apply to all providers.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page or electronic file in the record contains the patient's name or patient's Medicaid identification number and the office/practice from whom the page is coming.
2. All entries are dated.
3. The authors of all entries are identified.
4. The record is legible to someone other than the writer.
5. Medication allergies and adverse reactions, as well as the absence of allergies, are prominently noted and easily identifiable.
6. The patient's personal and biographical data— including age, sex, address, employer, home and work telephone numbers, and marital status—is recorded.
7. Medical history, including serious accidents, operations, and illnesses, is easily identified. For children, medical history includes prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization and administration.

9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded.
10. Patients aged 12 years and over are asked about smoking, alcohol, and other substance abuse at the routine visit and their answers are recorded.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Records of consultation and significantly abnormal labs and imaging results have an explicit notation of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with CA/CCNC.
14. Documentation of individual encounters provides adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test(s), therapies, and other prescribed regimen(s); follow-up care, referrals, and results thereof; and all other aspects of patient care, including ancillary services.

Referrals and Authorizations

Coordination of care is an important component of CA/CCNC. PCPs are contractually required to provide services or authorize another provider to treat the enrollee. A referral from the PCP to another provider should be considered even when an enrollee has failed to establish a medical record with the PCP when medically necessary health care services are needed. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of **Exempt Services** on page 4-13). All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. Referral of an enrollee to a specialist may be made by telephone or in writing. The referral must include the number of visits being authorized and the extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation, or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP must be contacted for authorization. The same authorization referral number must be used by both specialists.

Authorization is not required for services provided in an urgent care center billing with a hospital provider number. Referrals to a specialist for follow-up care after discharge from an urgent care center **do** require PCP authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. The **physician component for inpatient services does require authorization.** Referrals to a specialist for follow-up care after discharge from a hospital also require PCP authorization.

In addition to CA/CCNC authorization, prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of services. Refer to Section 6, **Prior Approval,** for additional information about services requiring PA.

CLAIMS SUBMITTED PRIOR TO NPI IMPLEMENTATION

CMS-1500 (08/05)—Effective January 1, 2007

CA PCP and Override Authorization

- Field 17a: Enter either the CA PCP provider number (the Medicaid provider number) or the CA ACCESS override number in the larger shaded field 17a. Qualifier 1D must precede the number in the smaller shaded field immediately to the right of the field identifier "17a."
- Field 17b: Enter the CA PCP NPI in this field. (N.C. Medicaid requests that providers immediately start submitting the NPI in addition to the Medicaid provider number.)

UB-04—Effective March 1, 2007

CA PCP and Override Authorization

- Form locator 78 (Other): Enter qualifier DN for Referring Provider in the first space. The NPI of the CA PCP may be entered in the second space identified as NPI. Enter either the CA PCP Medicaid provider number or the CA ACCESS override number with qualifier G2 in the third and fourth space identified as QUAL field.

CLAIMS SUBMITTED AFTER NPI IMPLEMENTATION

CMS-1500 (08/05)—Date to be determined

CA PCP Authorization

- Field 17a: Should be left blank for **Claims processed with CA PCP authorization**. CA claims do not require the taxonomy number for the referring provider. If you choose to enter the taxonomy number for the referring provider, qualifier ZZ must precede the number in the smaller shaded block immediately to the right of the field identifier "17a." If any value other than ZZ or blank is entered in field 17a, the claim will be denied.
- Field 17b: Enter the referring provider's NPI number for **Claims processed with CA PCP authorization.**

CA Override Authorization

- Field 17a: **Claims processed with CA Override authorization** requires the CA ACCESS override number in the larger shaded field 17a. Qualifier 1D must precede the number in the smaller shaded block immediately to the right of the field identifier "17a."
- Field 17b **Claims processed with CA Override authorization** will not have any information entered in field 17b.

UB-04—Date to be determined

CA PCP Authorization

- Form locator 78 (Other): **Claims processed with CA PCP authorization** require qualifier DN for Referring Provider in the first smaller block immediately to the right

of field identifier "78 Other" and the referring providers NPI number in the field labeled "NPI."

CA Override Authorization

- Form locator 78 (Other): **Claims processed with CA Override authorization** require qualifier DN for Referring Provider in the smaller block immediately to the right of field identifier "78 Other." No information should be entered in the field labeled "NPI." Qualifier G2 should be entered in the third smaller block immediately to the right of the field labeled "QUAL." The CA override number is entered in the fourth larger block directly to the right; this field is not labeled.

Referrals for a Second Opinion

CA/CCNC PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

Referral Documentation

All referrals must be documented in the enrollee's medical record. PCPs should review the monthly **Referral Report** to ensure that services rendered to their enrollees were authorized and have been documented and recorded accurately in each enrollee's medical record. It is the PCP's responsibility to review the Referral Report for validity and accuracy and to report inappropriate referrals to the Managed Care Consultant. Refer to page 4-24 for an example of the report.

Exempt Services

Enrollees may obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance services
- At-risk case management
- Child care coordination
- Community Alternatives Program services
- Dental care

  Note: CA/CCNC enrollees are instructed to contact their PCP for assistance in locating a dental provider enrolled with the Medicaid program. A list of dental providers is available on DMA's Web site at http://www.ncdhhs.gov/dma/dental/dentalprov.htm. Recipients can also be referred to the Office of Citizen Services, CARE-LINE Information and Referral, at 1-800-662-7030 or 919-855-4400 (English and Spanish).
- Developmental evaluations
- Eye care services [limited to CPT codes 92002, 92004, 92012, and 92014 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]

- Family planning (including Norplant)
- Health department services
- Hearing aids (for recipients under the age of 21)
- HIV case management
- Hospice
- Independent and hospital lab services
- Maternity care coordination
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist
- Services performed in a psychiatric hospitals and psychiatric facilities (but see notes below)
- Services provided by schools and Head Start programs

Notes to psychiatric services: Adult recipients (aged 21 years and older) are excluded when performed by an enrolled psychiatrist provider.

Diagnoses 290 through 319.99 are exempt for all providers excluding area mental health and psychiatrist providers. Area mental health and psychiatrist providers must adhere to Medicaid-specific policies on the DMA Web site.

Outpatient psychiatric services can be referred for children under the age of 21 by a Medicaid-enrolled psychiatrist, the local management entity, or the PCP.

Additional Note: Although enrollees are not required to obtain authorizations from their PCPs for the services listed above, PA may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the AVR system at 1-800-723-4337. Refer to Section 6, **Prior Approval,** for information on services requiring PA.

Override Requests

It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CA/CCNC enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers must request an override using the **Carolina ACCESS Override Request form** to obtain payment. However, override requests will be considered only if the PCP was contacted and refused to authorize treatment or if extenuating circumstances beyond the control of the responsible parties affected access to medical care.

Override requests must be submitted to EDS within 6 months of the date of service. Requests will be evaluated within 30 days of receipt. A copy of the **Carolina ACCESS Override Request form** is in **Appendix G-19** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms/html.

Medical Exemption Requests

CA/CCNC was established on the premise that patient care is best served by care coordinated through a PCP. Enrollees may request a medical exemption from participation in CA/CCNC. Depending on the condition of the patient, the exemption may be made for a 6-month period or for the lifetime of the patient. Exemptions are granted for the following medical conditions:

- Terminal illness—the enrollee has a life expectancy of 6 months or less or is currently a hospice patient
- Major organ transplant—this would be considered for a permanent exemption
- Chemotherapy or radiation treatment—the enrollee is currently undergoing treatment

  Note: This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than 6 months, the exemption must be requested after the initial 6-month time period during reapplication for Medicaid coverage.
- Diagnosis/Other—an enrollee may be granted an exemption if there is a specific diagnosis or other reason that the enrollee would not benefit from coordinated care through a PCP

  Note: Supporting medical record documentation for this category may be requested for review prior to a determination decision.
- End-stage renal disease

The **Carolina ACCESS Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the DMA Managed Care Section at the address listed on the form. Recipients may also obtain the Medical Exemption Request form at their county DSS. A copy of the form is also available in **Appendix G-20** or on DMA's Web site at http://www.ncdhhs.gov/dma.forms.html.

Patient Disenrollment

On occasion, it may be necessary to disenroll a CA/CCNC enrollee from a practice for good cause.* To disenroll a patient, PCPs must follow these procedures:

- Notify the CA/CCNC enrollee in writing of the disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days' notice. Advise the enrollee to contact his or her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.
- Fax a copy of the disenrollment letter to the managed care consultant.

Note: Until a DSS worker deletes the PCP's name, address, and telephone number from the recipient's MID card, the PCP must continue to provide services to the enrollee or authorize another provider to treat the enrollee.

***Good cause is defined as follows:**

- Behavior on the part of the recipient that is disruptive, unruly, abusive, or uncooperative to the extent that the provider's ability to serve the recipient or other affected recipients is seriously impaired
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment

- Fraudulent use of the Medicaid card

Additionally, a CA/CCNC enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, it is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

Carolina ACCESS—Frequently Asked Questions

1. **Is there a limit to the number of Carolina ACCESS patients that I can enroll for my practice?**
   PCPs may enroll up to a maximum of 2,000 CA/CCNC enrollees per physician or physician extender, unless otherwise approved by DMA.

2. **Can I change my enrollment limit?**
   PCPs may change enrollment limits or restrictions by completing and submitting a Medicaid Provider Change Form (see **Appendix G-3**).

3. **How can I verify that a patient is enrolled with Carolina ACCESS?**
   It is important to check the enrollee's current monthly MID card at each visit because the enrollee's eligibility status or medical home may have changed. If the patient is enrolled in CA/CCNC, the MID card will list the name of the medical home. If there is no medical home listed on the MID card, the patient is not currently in CA/CCNC.

   In addition to the verification methods listed on **page 2-12,** enrollment can also be verified by

   - Calling the AVR system
   - Checking the current Carolina ACCESS Enrollment Report

4. **What should I do if the patient does not bring his or her MID card to an appointment?**
   Verify the patient's enrollment by one of the methods listed on **page 2-11,** or check the current Carolina ACCESS Enrollment Report. Alternatively, prior to rendering the service, the provider must inform the patient either orally or in writing that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

5. **What if the medical home listed on the patient's MID card is incorrect?**
   Advise the patient to contact his or her caseworker or the Medicaid supervisor at the county DSS to request a change to another medical home. In most circumstances, the change takes a minimum of 30 days. Changes are always effective the first day of the month following the change.

6. **Are Carolina ACCESS enrollees responsible for co-payments?**
   CA/CCNC enrollees are subject to the same co-payment requirements as fee-for-service Medicaid recipients. Refer to **Co-payments** on page 2-18 for additional information.

7. **Do all Medicaid-covered services require authorization from the primary care provider?**
   No. Some Medicaid-covered services are exempt from PCP authorization. Refer to page 4-13 for a list of **Exempt Services.**

8. **What if a Carolina ACCESS enrollee assigned to my practice needs health care that my office cannot provide?**
   PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information on coordination of care.

9. **What is the process for referring a patient to a specialist or to other health services**?
   Prior to NPI implementation, the Medicaid number on your approved CA/CCNC application is the authorization number to be given to providers when referring an enrollee to a specialist or to other health services. The CA/CCNC enrollee may be referred to any specialist or to other health services enrolled with Medicaid. Effective with NPI implementation, you will use your NPI number as your authorization number. For more information about NPI, see http://www.ncdhhs.gov/dma/NPI.htm.

   Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

10. **What if my PCP practice receives a request for an authorization for a patient we have not seen yet?**
    Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, PCPs are not required to authorize a specialist or another health service provider to treat an enrollee who has not yet been seen in their practice. However, if the PCP does not authorize treatment, an appointment must be made available to the enrollee according to the standards of appointment availability (see **page 4-9**). All referrals must be documented in the enrollee's medical record.

11. **What if a Carolina ACCESS enrollee self-refers to our practice?**
    PCP authorization must be obtained before a CA/CCNC enrollee may see a specialist or another health service provider, unless the service is exempt from authorization. You may contact the PCP listed on the enrollee's MID card and request authorization, but the PCP is not obligated to authorize the service.

    If you do not receive authorization to treat the patient, you may refer the patient back to the PCP or inform the patient either orally or in writing, prior to rendering the service, that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

12. **Do Carolina ACCESS enrollees admitted through the emergency department require authorization from their primary care providers?**
    Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization.** Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

13. **How should claims be filed when a PCP refers a Carolina ACCESS enrollee to our office?**
    Refer to page 13 of the Billing Guide. Also you may refer to the June 2007 North Carolina Medicaid Special Bulletin, New Claim Form Instructions. (http://www.ncdhhs.gov/dma/bulletin.htm)

14. **Whom do I contact if I have questions or require additional information?**
    DMA has established regional managed care consultants to assist managed care providers. Refer to **page 4-28** for a list of consultants. If you are unable to reach the consultant, you may contact the DMA Managed Care program at 919-647-8170.

CA PROVIDER ENROLLMENT REPORT

SECTION 1

"New Enrollees"

	NC DEPT. OF HUMAN RESOURCES	PAGE NUMBER
PROVIDER NUMBER: 1234567	CAROLINA ACCESS	DATE RUN:
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT	
	FOR THE MONTH OF: SEPTEMBER	
	ENROLLMENT STATUS: **(NEW ENROLLEE)**	

				ELIGIBILITY DATES	
INDIVIDUAL I.D.	*CLIENT NAME / ADDRESS*	*SEX*	*BIRTHDAY*	*FROM*	*TO*
912345678K	RECIPIENT JOE D.	M	08/08/98	**09/01/03**	**11/30/03**
	123 MAIN STREET, NOWHERE NC 22231				
987654321P	RECIPIENT JANE A.	F	10/26/56	**09/01/03**	**02/28/03**
	123 ANY STREET, ANYWHERE NC. 22231				
999999999B	RECIPIENT JOHN E.	M	11/02/73	**09/01/03**	**12/31/03**
	123 MY STREET, ANYWHERE NC. 22231				

Note: This section of the report lists all **"New"** Carolina ACCESS enrollees linked to your practice for the report month. Some of the clients listed in this section may be previous clients who were listed in the **"Terminated"** section of a previous report.

Carolina ACCESS primary care physicians are encouraged to use this section of the report to identify and contact all new enrollees by telephone or through a "welcome" letter as a way of establishing a medical record with your practice.

Modified Example of the CA Provider Enrollment Report of Current Enrollees

CA PROVIDER ENROLLMENT REPORT

SECTION 2

"Current Enrollees"

	NC DEPT. OF HUMAN RESOURCES				PAGE NUMBER	
PROVIDER NUMBER: 1234567	CAROLINA ACCESS				DATE RUN:	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT					
	FOR THE MONTH OF: SEPTEMBER					
	ENROLLMENT STATUS: **(CURRENT)**					
				ELIGIBILITY DATES		
INDIVIDUAL I.D.	***CLIENT NAME / ADDRESS***		***SEX***	***BIRTHDAY***	***FROM***	***TO***
912345678K	RECIPIENT JOE D.		M	08/08/98	**09/01/03**	**12/31/03**
	123 MAIN STREET, NOWHERE NC 22231					
987654321P	RECIPIENT JANE A.		F	10/26/56	**09/01/03**	**10/31/03**
	123 ANY STREET, ANYWHERE NC. 22231					
999999999B	RECIPIENT JOHN E.		M	11/02/73	**09/01/03**	**09/30/03**
	123 MY STREET, ANYWHERE NC. 22231					

Note: This section of the report lists all Carolina ACCESS enrollees linked to your practice for the report month.

The eligibility "**FROM**" date listed for the client is always the current report month. The "**TO**" date will vary depending on each client's Medicaid certification period.

This section of the report can be used to verify **current month** eligibility if a client has not received their MID card for the current month or fails to bring the MID card to an appointment.

Modified Example of the CA Provider Enrollment Report of Terminated Enrollees

CA PROVIDER ENROLLMENT REPORT
SECTION 3
"Terminated Enrollees"

	NC DEPT. OF HUMAN RESOURCES				PAGE NUMBER	
PROVIDER NUMBER: 1234567	CAROLINA ACCESS				DATE RUN:	
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT					
	FOR THE MONTH OF: SEPTEMBER					
	ENROLLMENT STATUS: **(TERMINATED)**					
				ELIGIBILITY DATES		
INDIVIDUAL I.D.	***CLIENT NAME / ADDRESS***		***SEX***	***BIRTHDAY***		
				FROM	***TO***	
912345678K	RECIPIENT JOE D.		M	08/08/98	**09/01/00**	**08/31/03**
	123 MAIN STREET, NOWHERE NC 22231					
987654321P	RECIPIENT JANE A.		F	10/26/56	**04/01/03**	**09/30/03**
	123 ANY STREET, ANYWHERE NC. 22231					
999999999B	RECIPIENT JOHN E.		M	11/02/73	**06/01/03**	**09/30/03**
	123 MY STREET, ANYWHERE NC. 22231					

Note: This section of the report lists all of the Carolina ACCESS enrollees "**Terminated**" from your practice for the report month.

The eligibility "**FROM**" date and "**TO**" date listed for the client will vary indicating that:

- The client is no longer eligible for Medicaid; or
- The client is eligible for Medicaid but has selected another CA PCP, or has been granted an exemption for this report month; or
- A change was made to the client's file but was not entered into the system in time to generate a link to the "**New Enrollee**" section of the report for this month.

Example of Emergency Room Management Report

REPORT: HMSR300N

DIVISION OF MEDICAL ASSISTANCE
PRIMARY CARE PROVIDER
EMERGENCY ROOM MANAGEMENT REPORT
AS OF DATE: 11/27/2003

PAGE: 1
DATE: 11/27/2003

FIN PAYER: NCX1X

CLAIMS PAID DURING THE MONTH OF NOVEMBER 2003

COUNTY: ALAMANCE PCP: FUN FAMILY PRACTICE PCP NUMBER: 1234567

ENROLLEE NAME		MEDICAID NUMBER	PRIMARY DIAG.	REASON FOR VISIT	BILLING PROVIDER	DOS	TOS	PAID AMOUNT
IDENTIFIED EMERGENCIES								
COOL	JOE	F. 123456789M	7806	PYREXIA UNKNOWN ORIGIN	FUN HOSPITAL	10/26/03	11	$27.22
SMALL	SALLY	A. 987654321P	92310	CONTUSION OF FOREARM	CITY COUNTYHOSPITAL	10/18/03	14	$99.73
					TOTAL PAID AMT			$126.95
					TOTAL VISITS			2
OTHER ER CLAIMS								
DOE	JANE	R. 123456798W	6929	DERMATITIS NOS	LOCAL URGENT CARE	10/28/03	08	$28.52
					TOTAL PAID AMT			$28.52
					TOTAL VISITS			1
					AVERAGE PER VISIT			$28.52
					TOTAL ER PAID AMT			$155.47
					TOTAL ER VISITS			3

Example of Referral Report

11/27/2003
HMSR3501
FIN PAYER: NCXIX

DIVISION OF MEDICAL ASSISTANCE
REFERRAL REPORT FOR CAROLINA ACCESS PRIMARY CARE PROVIDERS
AS OF DATE: 11/27/2003

PAGE 1

CLAIMS PAID IN THE MONTH OF: NOVEMBER 2003

PCP NAME: ASHE CO HEALTDEPT
PCP NUMBER: 1234567
TOTAL NUMBER OF ENROLLEES DURING THE MONTH: 396

REFERRAL PROVIDER NAME	RECIPIENT NAME		SSN	DOB	FDOS	TDOS	AMOUNT
BOONE DERMATOGY CLINIC A	SMITH	JOE	111-11-1111	12/14/1986	11/02/2003	11/02/2001	$48.00
						TOTAL # OF REFERRALS:	1
						TOTAL AMOUNT :	$48.00
BOONE ORTHOPEC ASSOCIATS	SMITH	MARY	111-11-1111	09/27/1964	11/05/2003	11/05/2003	$29.11
BOONE ORTHOPEC ASSOCIATS	SMITH	SUE	111-11-1111	06/09/1964	11/05/2003	11/05/2003	$128.51
						TOTAL # OF REFERRALS:	2
						TOTAL AMOUNT :	$157.62
PROVIDER JOHN R	SMITH	JOHN	111-11-1111	11/05/1991	11/05/2003	11/05/2003	$68.00
						TOTAL # OF REFERRALS:	1
						TOTAL AMOUNT :	$68.00
						TOTAL AMOUNT FOR PCP:	$273.62

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXX

INSTRUCTIONS FOR QUARTERLY UTILIZATION REPORT

This report gives the PCP a detailed representation of the utilization of services by recipients linked with the PCP's practice. These reports are based on claims that were paid during the quarter prior to the report date. This report can be a useful tool in assisting the provider with their internal utilization and quality management programs.

There are 14 service categories listed on the top portion of the report, with an explanation of each listed on the second page of the report. The 14 service categories are divided into 4 subcategories as follows:

1. **Current Quarter PCP**—PMPM (per member per month) is the cost for that quarter for each of the 14 service categories. The rate = units (claims) divided by quarterly enrollment x 1000. Rates and cost are reported per 1000 members.
2. **Current Quarter PCP Peer Group**—Average rate and cost for all practices in your specialty for the quarter in respective category.
3. **Quarter Average for PCP Peer Group**—Average rate and cost for PCP Peer group practices in respective categories.
4. **Quarterly Average**—Totals for the last four quarters in respective categories.

IF YOU HAVE ANY QUESTIONS REGARDING THE QUARTERLY UTITLIZATION REPORT CONTACT YOUR REGIONAL MANAGED CARE CONSULTANT

Example of Quarterly Utilization Report

REPORT: HMSR4051 NORTH CAROLINA MMIS DATE: 04/20/2004
CAROLINA ACCESS QUARTERLY UTILIZATION REPORT
01/01/2004 - 03/31/2004

PRACTICE NAME: WE CURE WHAT AILS YOU MEDICAL OFFICE
PROVIDER NUMBER: 8888888
CA PCP TYPE: 001 - GP/FAMILY PRACTICE
COUNTY: 017 - CASWELL

**** OFFICE MANAGER: PLEASE DISTRIBUTE THIS REPORT TO ALL PHYSICIANS IN THE PRACTICE.

SERVICE CATEGORY	CURRENT QTR PCP RATE	CURRENT QTR PCP PMPM	CURRENT QTR PCP PEER GROUP RATE	CURRENT QTR PCP PEER GROUP PMPM	QUARTERLY AVE. LAST 4 QUARTERS - PCP RATE	QUARTERLY AVE. LAST 4 QUARTERS - PCP PMPM
(1) PCP OFFICE SERVICES	256	$14.01	292	$15.63	232	$13.52
(2) TOTAL ER/URGENT CARE SERVICES	28	$5.12	65	$17.44	48	$8.30
A. IDENTIFIED EMERGENCY	19	$2.71	38	$12.32	28	$5.48
B. NON-EMERGENT	9	$2.41	27	$5.12	20	$2.82
(3) PHARMACY	809	$35.16	1504	$81.72	758	$32.14
(4) HOSPITAL INPATIENT	9	$28.65	8	$45.20	3	$10.21
(5) INPATIENT MENTAL HEALTH	0	$0.00	1	$5.61	0	$0.00
(6) SPECIALISTS/REFERRALS	88	$13.95	169	$20.66	65	$8.07
(7) LABS	84	$2.84	70	$2.51	85	$2.63
(8) X-RAYS	1	$0.43	4	$2.54	1	$0.78
(9) MENTAL HEALTH OUTPATIENT	47	$5.69	97	$24.48	46	$4.79
(10) OUTPATIENT/AMBULATORY	47	$17.43	133	$43.07	38	$9.36

PMPM CALCULATIONS	CURRENT QUARTER PCP PMPM	CURRENT QUARTER PCP PEER GROUP PMPM	PCP LAST 4 QTRS PMPM	LAST 4 QUARTERS PCP PEER GROUP
(11) PRIMARY CARE PROVIDER	$16.01	$18.07	$16.40	$17.53
(12) ALL OTHER SERVICES	$133.13	$298.57	$99.51	$291.07
(13) TOTAL SERVICES	$149.13	$316.64	$115.91	$308.60

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: 51 AGES > 21: 20 AVERAGE TOTAL MONTHLY ENROLLMENT: 71

Example of Quarterly Utilization Report, continued

(1) NUMBER AND ASSOCIATED $ OF PCP OFFICE VISITS, INCLUDING OFFICE LABS/XRAYS AND HEALTH CHECKS
(2) ER/URGENT CARE VISITS AND ASSOCIATED $, IDENTIFIED EMERGENCIES = DMA DEFINED EMERGENCY DIAGNOSES (10/99 BULLETIN)
(3) PHARMACY SERVICES AND ASSOCIATED $ FROM DRUG CLAIMS
(4) HOSPITAL ADMISSIONS AND ASSOCIATED $ (INCLUDING ANESTHESIA). MENTAL HEALTH AND INPATIENT PHYSICIAN CONSULTATIONS ARE NOT INCLUDED.
(5) HOSPITAL ADMISSIONS AND ASSOCIATED $ FOR MENTAL HEALTH
(6) NUMBER AND ASSOCIATED $ FOR REFERRAL SERVICES TO SPECIALISTS, OTHER OUTPATIENT PROVIDERS, AND INPATIENT PHYSICIAN CONSULTATIONS PCP REFERRAL # IS ON THE CLAIM. (THIS DOES NOT INCLUDE OT/PT/ST OR MENTAL HEALTH).
(7) NUMBER AND ASSOCIATED $ IDENTIFIED FOR LABORATORY PROCEDURE CODES, PATHOLOGY INCLUDED.
(8) NUMBER AND ASSOCIATED $ IDENTIFIED BY X-RAY PROCEDURE CODES. THERAPEUTIC RADIATION SERVICES NOT INCLUDED.
(9) NUMBER AND ASSOCIATED $ FOR OUTPATIENT SERVICES RELATED TO MENTAL HEALTH.
(10) NUMBER AND ASSOCIATED $ FOR HOSPITAL OUTPATIENT SERVICES. THIS INCLUDES AMBULATORY, ANESTHESIA IN AN OUTPATIENT SETTING, HOME HEALTH, AND PT/OT/ST. E/R AND MENTAL HEALTH SERVICES NOT INCLUDED.
(11) QUARTERLY AND ANNUAL PMPM FOR PCP SERVICES INCLUDING MANAGEMENT FEES FOR PCP AND PCP PEER GROUP
(12) QUARTERLY AND ANNUAL PMPM FOR LINES 2-10 AND ALL NON-PCP SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
(13) QUARTERLY AND ANNUAL PMPM FOR ALL SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP
(14) AVERAGE MONTHLY NUMBER OF RECIPIENTS LINKED WITH THIS PCP.

NOTE: THESE FIGURES ARE BASED ON CLAIMS PROCESSED FOR SERVICES PROVIDED DURING THE QUARTER REPORTED

MEDICARE CROSSOVER CLAIMS AND ADJUSTMENTS NOT INCLUDED
RATE = UNITS / QUARTERLY ENROLLMENT X 1000.

List of Regional Managed Care Consultants

Consultant's Name	Telephone Number	E-mail Address	Counties
Jerry Law	252-321-1806	Jerry.Law@ncmail.net	Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Martin, Nash, Northampton, Pasquotank, Perquimans, Pitt, Tyrell, Washington
Rosemary Long	910-738-7399	Rosemary.Long@ncmail.net	Bladen, Brunswick, Carteret, Columbus, Craven, Cumberland, Duplin, Jones, Lenoir, New Hanover, Onslow, Pamlico, Pender, Robeson, Sampson, Wayne
Lisa Gibson	919-319-0301	Lisa.Gibson@ncmail.net	Davidson, Davie, Forsyth, Guilford, Hoke, Montgomery, Moore, Randolph, Richmond, Rockingham, Scotland, Stokes, Surry, Wilkes, Yadkin
Christopher Lucas	919-647-8176	Christopher.Lucas@ncmail.net	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Harnett, Johnston, Lee, Orange, Person, Vance, Wake, Warren, Wilson
LaRhonda Cain	919-647-8190	LaRhonda.Cain@ncmail.net	Alexander, Alleghany, Anson, Ashe, Cabarrus, Caldwell, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union, Watauga
Melanie Whitener	828-304-2345	Melanie.Whitener@ncmail.net	Avery, Buncombe, Burke, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey